

‘What Really Happened’ Versus ‘What We Can Prove’: Tension Between the Roles of Coroner and DPP in Queensland

Geraldine Mackenzie¹, Nigel Stobbs² and Mark Thomas²

Author Version of

Mackenzie, Geraldine and Stobbs, Nigel and Thomas, Mark (2007) *'What really happened' versus 'What we can prove': tension between the coroner and the DPP*. *Indigenous Law Bulletin*, 6 (24). pp. 6-10. ISSN 1328-5475

Accessed from USQ ePrints <http://eprints.usq.edu.au>

¹Associate Professor, Faculty of Law, Queensland University of Technology

²Lecturer, Faculty of Law, QUT

Introduction

According to Queensland law, any death which occurs in police custody must be subject to a coronial inquest.^[1] Such an investigation is required by best practice guidelines to have regard, where applicable, for the recommendations and findings of the *Royal Commission into Aboriginal Deaths in Custody*^[2] ('RCIADIC') and to be conducted in such a way as to be more sensitive and compassionate towards families than has been the case in the past.^[3]

Coronial Inquest into the Death of Mulrunji

Mulrunji (the deceased's tribal name), a 36-year-old Aboriginal man resident on Palm Island, died in police custody in the Palm Island watch-house on 19 November 2004. There is no reason to believe that, had he not been in custody, this man would have died on that day. He was described by the Coroner as a 'fit, healthy man' who had no prior history of arrest and who was not a 'troublemaker'.^[4] In the ensuing investigation, Acting State Coroner Christine Clements found that the arrest of Mulrunji Doomadgee was not an appropriate exercise of police discretion and that police investigations into the circumstances of his death were 'reprehensible' and significantly lacking in transparency, objectivity and independence.^[5] She concluded that Mulrunji died subsequent to the arresting officer – Senior Sergeant Chris Hurley – losing his temper and becoming involved in a violent altercation with Mulrunji.^[6]

The finding of facts^[7] by the Coroner were, briefly, as follows. On 19 November 2004, three Indigenous women were assaulted by the de facto of one of them. After talking to the women, Senior Sergeant Hurley, the officer in charge on Palm Island, accompanied one of the women and an Indigenous Police Liaison Officer ('PLO') back to her residence to collect her medication as she was afraid of being further assaulted. At the residence, Hurley arrested a young man who was drunk and abusive. Mulrunji (who was intoxicated) was walking past at this time and stopped to ask the PLO why he would get involved in locking up his own people. The PLO reported, in response to a question from Hurley, that Mulrunji had questioned the PLO's actions. Mulrunji turned and swore at the officers while walking away. Hurley then approached Mulrunji and arrested him (at about 10:20am). There was some evidence that the purported reason for the arrest was to check if there were any outstanding warrants on Mulrunji.^[8] At the watch-house garage, Hurley removed Mulrunji from the back of the police vehicle. Mulrunji resisted and lashed out with the back of his fist, striking Hurley in the jaw.^[9] There was evidence that Hurley then struck Mulrunji in the torso several times^[10] after which both men fell through the doorway between the garage and the watch-house proper, which contained a concrete step covered in lino. Ms Clements found that Hurley landed beside Mulrunji and punched him a number of times while he (Mulrunji) was still on the ground.^[11] Hurley claimed at the coronial inquest that what witnesses thought were punches were actually his attempts to help Mulrunji to his feet and that each time he grabbed Mulrunji's shirt it would tear and he had to try again.^[12]

Unchallenged expert medical opinion (which the coroner accepted) was that neither the blows inflicted by Hurley nor a fall onto the floor itself could have caused the injuries which killed Mulrunji.^[13] The Coroner concluded that the fatal injuries must have occurred during the fall at the entry to the Police Station, however, in light of Senior Sergeant Hurley's consistent statements, also found that he fell to the left of Mulrunji,^[14] rather than onto him with compressive force.^[15] It was agreed that after the fall, Hurley and another officer dragged Mulrunji (who had stopped resisting) to a cell where he lay on the floor.^[16] Mulrunji was found to be dead in the cell at 11:20am.^[17]

The Coroner found that Mulrunji suffered four broken ribs and a ruptured liver and portal vein.^[18] An autopsy revealed at least one and a half litres of blood and clot in the peritoneal cavity and the liver almost completely cleaved in two.^[19]

The Coroner's Powers

When presenting the new [Coroners Act 2003](#) (Qld) to the State Parliament, Attorney-General Rod Welford was at pains to explain that the amendments to the powers of the State Coroner were largely aimed at expanding the powers of the Coroner to obtain information and evidence, to 'find out what really happened to cause the death and make meaningful recommendations to prevent it happening again.'^[20] One of the additional powers to which the Attorney-General was referring was the power of the Coroner to compel a person to give evidence, even where that evidence would tend to incriminate the person.^[21] Hurley was subject to such a compulsion in the Mulrunji inquest.^[22] The safeguards which balance this extension of power include a prohibition on any evidence so obtained being used in later criminal proceedings (except where there may be a charge of perjury).^[23] Mr Welford also advised that there would be a removal of the power of the coroner to commit a person for criminal trial.^[24] The removal of this power, he claimed, was to bring the law in line with 'interstate trends'.^[25]

[Section 48](#) of the [Coroners Act 2003](#) (Qld) provides that if a Coroner reasonably suspects that a person has committed an offence, the Coroner must give the information to the prosecuting authority – and where this involves a more serious offence, this information must be given to the Director of Public Prosecutions ('DPP'). Reasonable suspicion about police misconduct must be given to the Crime and Misconduct Commission ('CMC'). In accordance with [section 39](#), the information to be given to the DPP or CMC is to *exclude* any evidence provided to the inquest by a person who has been compelled to give evidence. [Section 45\(5\)](#) of the Act expressly prohibits the Coroner from making any statement that a person is, or may be, guilty of an offence.

Mindful of these requirements and prohibitions, Ms Clements balanced this with what she referred to as the 'competing interest of the family of the deceased who have a legitimate interest in knowing how the coroner has discharged this statutory obligation [to report] if it arises.'^[26] The Coroner then indicated that she had considered her statutory obligations to inform prosecuting authorities without mentioning names or alleged offences.^[27] She also provided details of this information to the family of the deceased and to the legal representatives of anyone to be named to the DPP or CMC.^[28]

The Involvement of the Director of Public Prosecutions

The conduct of Hurley was referred to and considered by both the CMC and the DPP. After considering the evidence available to her, Leanne Clare SC – the Director of Public Prosecutions for Queensland – found that this evidence was 'not capable of proving Senior Sergeant Hurley was criminally responsible for Mr Doomadgee's death.'^[29] In making this decision, Ms Clare noted that some of the key witness statements had changed over time. She made no mention in her media release that the statements of Hurley himself had also changed in a highly significant way over time.^[30] The DPP emphasised that the medical evidence that Mulrunji's fatal injuries had occurred as the result of a 'complicated fall' were as yet unquestioned. She said that 'neither kicks nor punches are likely to have caused Mr Doomadgee's death. On the evidence, the fall is the only satisfactory explanation for the injuries identified by doctors.'^[31]

She makes this conclusion: ‘In other words, the admissible evidence suggests that Mr Doomadgee’s death was a terrible accident.’^[32]

In concluding that the death of Mulrunji was an accident, Ms Clare seems to be conflating her role with that of the Coroner. Determining the cause of death is a coronial function – not an administrative function. If Ms Clare were of the view that the evidence which she considered to be admissible (and ultimately that is a matter to be determined by a judicial officer, not the DPP) was not capable of establishing a homicide, then that is a determination she is both entitled and required to make according to [section 10\(1\)](#) of the [Director of Public Prosecutions Act 1984](#) (Qld). But to then conclude that this somehow means that the death was, in fact, an accident is inappropriate and not within her jurisdiction. She may well form a personal view that an accident is the most likely explanation for the death, but it is the role of the Coroner to determine this.

Ms Clare expressly acknowledges that her duties ‘are different to those of the coroner... [and that this] may lead to different views being reached in the same case, without questioning the process and findings of the coroner.’^[33] But in stating that this death was a terrible accident, the DPP has in fact questioned the finding of the Coroner. In a further indication that the executive in Queensland seems to be in some confusion as to the nature and roles of the DPP and the State Coroner, Police Minister Judy Spence stated that she supported Ms Clare’s decision and told *The Australian* that she ‘could understand why it was difficult for people to see how two arms of the judicial system could come to two different conclusions.’ She stated: ‘I just remind people that it is common for judges to disagree.’^[34] The DPP is not a judicial officer and, in presiding over an inquest for the purposes of the enabling legislation, a coroner is not exercising a judicial function either. Any suggestion that either of those roles was judicial in nature could only be made in ignorance of the doctrine of the separation of powers.

What is potentially most disturbing about this matter is that many of the public officials involved (and therefore possibly both the Indigenous and wider communities) may believe that the Coroner and the DPP have come to different conclusions about the same matter. They have in fact been asked to consider quite different matters.

Contrasting Roles: The Coroner and the DPP

Ms Clements was asked to consider what, in fact, caused the death of Mulrunji. In doing so, the Coroner gave some thought to what standard of proof would be required in making adverse findings against Hurley, and properly adopted the *Briginshaw* test.^[35] Essentially, *Briginshaw* requires that the more serious the allegation and the more grave the consequences of a finding, the clearer or more persuasive the evidence must be before a tribunal of fact can be satisfied to the civil standard of ‘the balance of probabilities’. Moreover, the case authority to which the Coroner referred in her decision clearly comprehends the significance of potential criminal proceedings, and the need to have regard to the presumption of innocence in making adverse findings against a person in relation to the causing of the death of Mulrunji.^[36]

The DPP was asked, however, whether as a matter of law the evidence available to her office was strong enough to present a reasonable prospect of a criminal conviction based on the criminal standard of proof – beyond reasonable doubt. In declaring that the death was a terrible accident Ms Clare has both usurped the role of the Coroner and come to an inappropriate conclusion. In doing so, the DPP, the Minister for Police and the Premier have

created a furore over this matter which was quite possibly avoidable. Days after Ms Clare made her press release, the Federal Indigenous Affairs Minister Mal Brough urged Premier Peter Beattie to seek a second opinion.^[37] The Premier dismissed any possibility of this as ‘political interference’.^[38]

The reference by Ms Clare in her media statement to ‘further lines of inquiry’^[39] and ‘additional evidence’^[40] which she says she pursued and which justify her decision not to indict Hurley does little to allay fears that she has misconceived her role. At the coronial inquest, Ms Clements drew attention to the fact that in four interviews prior to the coronial hearing (three conducted by the Queensland Police Service (‘QPS’) and one by staff of the CMC), Hurley had made clear and consistent statements that he had not fallen on top of Mulrunji.^[41] When asked by the QPS-appointed investigating officer, for example, how he had fallen, Hurley replied: ‘I fell to the left of him and he was to the right of me.’^[42] Medical evidence indicated that the injuries suffered by Mulrunji could only have been caused by a very significant compressive force.^[43] When under oath at the inquest, Hurley stated: ‘If I didn’t know the medical evidence, I’d tell you that I fell to the left of him. The medical evidence would suggest that that wasn’t the case.’^[44]

Trials and Rules of Evidence

A definitive feature of the criminal justice system in common law jurisdictions such as Australia is that it is not the purpose of a trial to discover the truth about what happened in relation to any event. An adversarial trial is more about a contest to determine which party can best prove its version of events rather than a search for the factual truth. And the evidence presented to a jury is generally that evidence which each side considers will put its case in the best light – not necessarily the evidence that is more likely to explain what occurred.^[45]

In circumstances where the technical legal rules of the admissibility of evidence (and there are many of them) may well make it unlikely that adversarial criminal proceedings would involve the analysis of enough information to make a determination as to the actual cause of a person’s death, State Coroners generally have the power to make more widespread and thorough investigations.^[46]

Implementation of RCIADIC Recommendations

Apart from the confusion and damage to the relationship between Indigenous people and the QPS which may have been caused by some of the conflationary comments made by the DPP and members of the State Government, this matter is also a stark reminder that despite the extensive conclusions and recommendations of RCIADIC, both the number of Indigenous people being taken into custody in Australia and the number of Indigenous people dying in custody has continued to rise.^[47]

Acting State Coroner Clements highlights the way in which some of the most basic recommendations of RCIADIC have not been properly implemented in Queensland. The [*Police Powers and Responsibilities Act 2000*](#) (Qld) (‘PPR Act’) was drafted to expressly enact some of these recommendations. Notably, section 378 of the PPR Act provides that if a police officer is arresting a person for being drunk in a public place, the person may be taken to a place other than a watch-house where they can recover safely from the effects of being drunk. This could be a hospital, the home of a relative or friend, or the person’s own home. In the context of Mulrunji having no prior history of arrest and being unknown to Hurley, the

suggestion that he was being taken to the watch-house to check for outstanding warrants seems more of an overt assertion of authority and an example of the perennial problem of over-policing of Indigenous people. There is ample evidence that diversionary centres which exist in some larger areas are effective, but the lack of any such facility on Palm Island is a serious failing in light of RCIADIC. Ms Clements strongly recommended changes to the QPS Operational Procedures Manual to include instructions to consider arrest as a last resort and to consider alternatives (such as cautions) when confronting a person about minor offences.^[48]

Ms Clements was scathing in her assessment of the way in which this death in custody was investigated by the Queensland Police Service and the procedures adopted seem quite contrary to the recommendations and spirit of RCIADIC.^[49] Of particular concern was the fact that a number of investigating officers were personal acquaintances or friends of Hurley and two of these officers in fact had dinner with him on the day of their investigation.^[50] One would have thought that the Coroner's recommendation that '[i]n all deaths in custody, officers investigating the death should be selected from a region other than that in which the death occurred'^[51] would have been a matter for immediate operational adoption after the release of RCIADIC. It is, however, arguably so obvious that it is remarkable that it needed a royal commission to spell it out.

The failure of officers to conduct an initial assessment of Mulrunji's health upon his confinement in the watch-house cell^[52] and the fact that he was left to die on the cell floor is of course totally unacceptable in a post-RCIADIC custodial environment in Australia. The Coroner also stated that she had 'no doubt that one particular cry out for help by Mulrunji must have been heard in the police station'.^[53] In the RCIADIC National Report, Commissioner Johnston QC made extensive comment on the extent and nature of the duty of care owed by police and corrections staff to those in custody, and concluded with 'the strongest impression that many police officers had (particularly until recently) only the haziest notion (if any) that they and their employers owed a duty of care to prisoners and what this duty of care entailed. This inattention has been reflected in their training and experience.'^[54] Considering that 15 years has passed since the Commissioner made this assessment, it is disheartening to read the Acting State Coroner's finding that '[t]he failure to properly assess Mulrunji's health suggests a lack of appropriate training for officers in the conduct of health assessments of people in custody'.^[55] Also, considering that no effort was made to resuscitate Mulrunji^[56] and that he died from such a significant injury in such a short period of time, Ms Clements' recommendations that all watch-house staff be given theoretical and practical training in resuscitation^[57] (presumably in addition to their mandatory first aid training) and that persons in such custody should not be left unmonitored under any circumstances^[58] are difficult to reconcile with the rhetoric and assurances about extant reforms that we are used to hearing in relation to Indigenous custody issues.

Conclusion

Considering the significant failures to properly implement key recommendations of the RCIADIC which are highlighted by this matter, it seems odd that the DPP in Queensland would describe this death as an accident at all (regardless of whether it was her prerogative to do so). The chain of events beginning with an intoxicated Aboriginal man swearing at police (and thereby challenging their authority) and the exuberant use of arrest powers, leading to an aggressive police officer wrestling with and striking the man, and detaining him in a watch-house which did not (according to the Coroner) display even the most basic procedural safeguards recommended by RCIADIC^[59] seems to characterise this death as a

tragic inevitability rather than as a tragic accident. It is an old story and one which apparently refuses to go away.

Postscript

On 4 January 2007, Sir Laurence Street (a former New South Wales Chief Justice) was appointed to conduct an independent review of the material as assessed by the DPP. Sir Laurence is expected to complete his review within five weeks.

[1] [Coroners Act 2003](#) (Qld) [ss 8](#) and [11](#).

[2] Commonwealth, *Royal Commission into Aboriginal Deaths In Custody*, National Report (1991) <<http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/index.html>> at 12 January 2007.

[3] Queensland Coroner's Guidelines at <<http://www.justice.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>> at 10 January 2007; Commonwealth, *Royal Commission into Aboriginal Deaths in Custody, National Report* (1991), Inquest Findings and Recommendations 108 and 110 in relation to 'The Rights of the Deceased's Family'.

[4] Office of the State Coroner (Qld), *Finding of Inquest – 'Inquest into the Death of Mulrunji'* (27 September 2006) COR 2857/04(9), 2.

[5] *Ibid* 33.

[6] *Ibid* 26-27.

[7] *Ibid* 2.

[8] *Ibid* 3.

[9] *Ibid* 25.

[10] *Ibid* 11.

[11] *Ibid* 27.

[12] *Ibid* 20 and 26.

[13] *Ibid* 7.

[14] *Ibid* 27.

[15] *Ibid* 7 and 8.

[16] *Ibid* 21.

[17] Ibid 15.

[18] Ibid 7.

[19] Autopsy report of Dr Guy Lampe (2004).

[20] Queensland, *Parliamentary Debates*, Legislative Assembly, 3 December 2002, 5222 (Rod Welford Attorney-General).

[21] [Coroners Act 2003](#) (Qld) [s 39](#).

[22] Office of the State Coroner (Qld), above n 4, 12.

[23] [Coroners Act 2003](#) (Qld) [s 39](#).

[24] Queensland, *Parliamentary Debates*, Legislative Assembly, 3 December 2002, 5222 (Rod Welford Attorney-General).

[25] Office of the State Coroner (Qld), above n 4.

[26] Ibid 34.

[27] Ibid.

[28] Ibid.

[29] Office of the Director of Public Prosecutions, ‘Hurley Not to Face Criminal Charges’ (Press Release, 14 December 2006).

[30] Office of the State Coroner, above n 4, 25. In her Finding of Inquest, Acting State Coroner Clements found that ‘Senior Sergeant Hurley was quite clear on every occasion, until he came to court, that he had not fallen on Mulrunji... In his evidence to this court Senior Sergeant Hurley merely said he must have fallen on Mulrunji. What has brought this change of recollection after repeated adamant accounts that he fell to the left hand side? The reality is that Senior Sergeant Hurley has become aware exactly of the nature of Mulrunji’s injuries causing death. If he had not otherwise caused such injury to Mulrunji, then the injury must be explained in the fall.’

[31] Director of Public Prosecutions, above n 29.

[32] Ibid.

[33] Ibid.

[34] Tony Koch and Patricia Karvelas, “‘White Justice’ Ruling puts Heat on Beattie’, *The Australian* (Sydney), 16 December 2006, 1.

[35] *Briginshaw v Briginshaw* [\[1938\] HCA 34](#); (1938) 60 CLR 336.

[36] *Annetts v McCann* (1990) 65 ALJR 167, 168.

[37] 'End Custody Death Confusion', *Sydney Morning Herald* (Sydney), 15 December 2006.

[38] Tony Koch and Patricia Karvelas, above n 34.

[39] Office of the Director of Public Prosecutions, above n 29.

[40] *Ibid.*

[41] Office of the State Coroner (Qld), above n 4, 27.

[42] *Ibid* 13.

[43] *Ibid* 7 and 9.

[44] *Ibid* 22.

[45] For a discussion of the fundamentals of the adversarial system of litigation see Nigel Stobbs, 'The Adversarial Court System – Is it Fair?' in Sharon Hayes, Nigel Stobbs and Mark Lauchs (eds), *Social Ethics for Legal and Justice Professionals* (2006) 59.

[46] [*Coroners Act 2003*](#) (Qld), [s 37](#) and Division 3 generally.

[47] Australian Bureau of Statistics, '1301.0 Year Book Australia 2006' (2006), Chapter 11 – Crime and Justice,
<<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/B237B6EA78BC3729CA2570DE0013591F?opendocument>> at 24 January 2007.

[48] Office of the State Coroner (Qld), above n 4, 28.

[49] *Ibid* 9-10 and 31-32.

[50] Office of the State Coroner (Qld) above n 4, 31. The Acting State Coroner made detailed recommendations about the need for actual and perceived impartiality in any investigation of a death in custody, noting that Hurley had in fact collected investigating officers from the airport himself and driven them to the scene of the death. It was also inappropriate that Hurley had discussed details of the death with other officers who were witnesses, prior to their being interviewed.

[51] *Ibid.*

[52] *Ibid* 29.

[53] *Ibid* 32.

[54] Commonwealth, *Royal Commission into Aboriginal Deaths in Custody*, National Report (1991) Volume 1, 3.3.14,
<<http://www.austlii.edu.au/au/special/rsjproject/rsjlibrary/rciadic/national/vol1/70.html>> at 23 January 2007.

[55] Office of the State Coroner (Qld), above n 4, 30.

^[56] Ibid 18.

^[57] Ibid 30.

^[58] Ibid.

^[59] Ibid.